recognise the problem and consequent lack of treatment might aggravate disability in survivors.

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1 Barer D. Lower cranial nerve motor function in unilateral vascular lesions of the cerebral hemisphere. *Br Med J* 1984;289:1622.
2 Barer D, Cruickshank J, Ebrahim S, Mitchell S. Low dose beta blockade in acute stroke (the "BEST" trial). *Br Med J* (in press).

Struggling with malpractice and medical defence subscriptions

SIR,—Several correspondents on the issue of medical defence subscriptions (12 September, p 666) suggest that health authorities should bear the cost on the grounds that it is common practice for employers in industry to take out insurance for their workers.

Such a move will protect hospital doctors from the burden of rising professional indemnity subscriptions. This practice may, however, cause problems. Currently, the defence organisations offer protection not only against claims for negligence from patients but also against actions initiated by the employing authorities on matters related to contractual obligations or by the General Medical Council's disciplinary committees. If the employing authorities pay the defence subscriptions a conflict of interests may arise in defending the doctor against actions initiated by the employer.

As costs of negligence rise defence societies will probably be under pressure to limit or withdraw their support of individual members in cases relating to contractual commitment of professional conduct, especially where negligence to a patient is not in question. In many such instances failure to defend the member successfully will not result in financial losses to the defence organisations. I believe that if employing authorities take over payment of defence subscriptions it is imperative to have separate indemnity dealing solely with problems in disputes entailing the employing authority or the General Medical Council. Subscription for this important protection should be paid by individual members.

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Reviewing RAWP

SIR,—Mr N B Mays (19 September, p 703) calls for greater empirical evidence on whether patients in "socially deprived" areas stay in hospital longer for the same case mix than those in "non-deprived" areas in order to assess the need for an allowance for deprivation in National Health Service resource allocation formulas.

Simple observations of a correlation do not, however, imply causation. As a consequence, enhancing the provision of resources in areas observed to have atypically long lengths of stay generates perverse incentives, encouraging longer lengths of stay in all areas to substantiate further additions to existing allocations, and hence undermines the fundamental principle of a RAWP type formula. The results of a recent comparison of activity between Sheffield and West Lambeth health authorities suggested that observations of longer lengths of stay in inner London districts are less to do with the relative deprivation of the population and more concerned with managerial practices and the efficiency of performance of the particular districts.[1]

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1 George SL, Pitt FA, Watts M. Impact of cuts in acute beds on services for patients. *Br Med J* 1987;294:969.

Determining the incidence of HIV infection

SIR,—The debate surrounding the determination of the incidence of infection with the human immunodeficiency virus (HIV) in the general population in Britain has so far failed to identify an ethically acceptable programme. The continuing need for some system of monitoring HIV seroprevalence, however, cannot be ignored. Indeed, the World Health Organisation emphasises, in its special programme on the acquired immune deficiency syndrome (AIDS), that national AIDS programmes should include the establishment of AIDS and HIV surveillance.[1]

A random sample for whom HIV seropositivity would be of least personal impact would be those killed in road traffic accidents each year (5000 in England and Wales[2]). While the results of such a monitoring scheme would need to be adjusted to reflect the British population, it is noteworthy that the age distribution of people who die in road traffic accidents is similar to the age distribution of people who are sexually active. Furthermore, details of age, sex, and social class would be readily available without the complications that obtaining such details during a random study of HIV seroprevalence among hospital admissions would entail.

Random and anonymous studies all suffer from the limitation that risk group data are inaccessible, a failing noted by the Social Services Committee.[3] The availability of data on social class and geographical locality for those killed in road traffic accidents, however, encourages the review of demographic influences on the spread of HIV, an approach which may outlast the current reliance on risk group classification and which is in line with the World Health Organisation's global strategy.

The current estimate of HIV infection in Britain (30 000-100 000) would be reflected by 3-10 people infected with HIV among those killed in road traffic accidents each year, given a geographically similar distribution of deaths in such accidents and infection with HIV. In fact, because of the preponderance of deaths in road traffic accidents occurring in the sexually active age range there would be a positive bias towards seropositivity for HIV. Such a bias would be neutralised by normalisation of the data but would tend to improve the statistical reliability by increasing the numbers counted. The statistical confidence for one year for Britain would allow no better resolution than the current guesswork. Over time and if the approach were broadened—for instance, to Europe—the study would become more statistically powerful. In any event, it is in the trends of infection that the really crucial pointers for the future lie.

While ethical dilemmas about informing next of kin of positive results would inevitably arise, with the current demand for transplantable organs much of the HIV testing would have been carried out anyway. Thus the HIV state of the British population might be assessed with minimal intrusion and cost to individuals or to society.

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1 World Health Organisation. *Special programme on AIDS. Strategies and structure, projected needs*. Geneva: World Health Organisation, 1987: 5, 9, 14.
2 Office of Population Censuses and Surveys. *Mortality statistics, accidents and violence, England and Wales 1985*. London: Office of Population Censuses and Surveys, 1986. (Series OH4 No 11.)
3 Social Services Committee. *Third report of the social services committee session 1986-87. Problems associated with AIDS*. London: HMSO, 1987:13.

Doctors against nuclear war in Turkey

SIR,—As community physicians we are concerned for Turkish colleagues who currently face government oppression resulting from their wish to publicise the BMA reports on the medical effects of nuclear war.[1,2] Last May these doctors and health workers applied for government permission to form a group opposed to nuclear war but their request was refused on the grounds that they might alarm the public and that they should leave the issue to experts—namely, the Atomic Energy Authority and the Civil Defence Department of the Ministry of the Interior.[1]

Government refusal to recognise this medical group means that Turkey is unique in having prevented its doctors and health workers from becoming affiliates of the Nobel prizewinning International Physicians for the Prevention of Nuclear War (IPPNW). With Albania and Yugoslavia, Turkey is one of only three European countries without affiliate membership of IPPNW, to which more that 50 countries now belong.

A second consequence of government refusal to register Doctors Against Nuclear War is that members of this 60 strong group face the penalties of belonging to an illegal organisation. In Turkey punishment for opposing the government or its regulations can be severe. A number of doctors who opposed increased government control over the universities have been dismissed from their posts without warning.[4] Some have also had their passports withdrawn and have been told they may never work again for a state university or for the state health service. Even more disturbing is the fact that doctors in Turkey, including Dr Erdal Atabek, a past president of the Turkish Medical Association, have been imprisoned. Dr Atabek was imprisoned for membership of the Turkish Peace Association, a multiprofessional group, which existed to support détente and multilateral disarmament. In so far as Turkey is a member of NATO, this abuse of human rights makes a mockery of NATO's claim to defend democratic rights, including that of peaceful dissent.

Letters have been received from the community physician secretary of Doctors Against Nuclear War and also from the secretary general of the Turkish Medical Association asking for our support. We therefore urge the BMA to press for the denial of the European Community membership that Turkey requests until her deplorable human rights record improves.

We also ask individual colleagues to send letters of protest to both their United Kingdom and their European MPs, and to invite Turkish physician members of Doctors Against Nuclear War to professional conferences in Britain as a means of pressing for the return of their passports. We would be glad to supply details to anyone prepared to help in this or any other way.

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